A9

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NON-COUNTY ANNUAL HEALTH SCREENING INSTRUCTIONS

You are required to obtain a health clearance annually. Health screening clearance must be completed each year the same month as your last tuberculosis(TB) screening date. For example, if your last TB screening was completed on June 15, 2017, you must obtain the next health clearance by June 30, 2018. This packet includes health screening forms and questionnaires that should be completed by you and your physician or a licensed health care professional prior to your visit to EHS for your health clearance. **Completed E2s forms can be submited to EHS on the day or your appointment/visit or via email.** This packet contains the following forms/questionnaires:

- ✓ **E2 Annual Health Screening**– This form contains health questionnaire and tuberculosis screening. Annual influenza vaccine status must be documented as either received or declined. If declining, you will need to wear a mask during the influenza season while in the facility.

- ✓ **K-NC** – This form is a declination to receiving vaccines.

- ✓ **N-NC** – This form is used for a N95 respirator fit test to be completed by your PLHCP. If your job assignment requires a N95 respirator, you must be fit tested for the N95 respirator. If your job assignment involves Airborne Infection Isolation Rooms (AIIR), you will need to be fit tested. If your job assignment does not involve AIIR, you will not need to complete this form or the questionnaire below (Form P-NC).

    - **P-NC** – This form is an Aerosol Transmissible Disease Respirator Medical Evaluation Questionnaire. You must complete this questionnaire and submit to your PLHCP **prior** to the respirator fit test.
      ****NOTE**:** N95 respirator is the most commonly used respirator in DHS facility, however, if you need a respirator greater than a N95 (such as full-face respirator), you must complete the Respirator Medical Evaluation Questionnaire (Form O-NC) and submit to your PLHCP prior to fit test. Form O-NC is available on EHS link at www.dhs.lacounty.gov .

Once you have been cleared by EHS, you will be given an annual health clearance certificate. If you have any questions, please contact the facility EHS.

Sincerely,

EMPLOYEE HEALTH SERVICES

E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
ANNUAL HEALTH QUESTIONNAIRE AND SCREENING

☞ See GENERAL INSTRUCTIONS on last page

FOR NON-DHS/NON-COUNTY WFM

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	E or C#:
E-MAIL ADDRESS:	HOME/CELL PHONE#:	DHS FACILITY:	DEPT/WORK AREA/UNIT:
JOB CLASSIFICATION:	NAME OF SCHOOL/EMPLOYER/AGENCY/SELF:	AGENCY CONTACT PERSON	AGENCY PHONE:

In accordance with Los Angeles County, Department of Health Services policy 705.001, Title 22, and CDC guidelines all contactors/students/volunteers working at the health facilities must be screened for communicable diseases annually. This form must be signed by a healthcare provider attesting all information is true and accurate OR workforce member may supply all required source documents to DHS Employee Health Services.

MEDICAL HISTORY UPDATE - Check any of the following conditions you have had since your last health evaluation.

Allergies:

☐ No ☐ Yes	Chest pains	☐ No ☐ Yes	Skin problem/rash
☐ No ☐ Yes	Elevated blood pressure	☐ No ☐ Yes	Exposure to communicable disease: _____
☐ No ☐ Yes	Dizziness or fainting spells		
☐ No ☐ Yes	Problems with mobility	☐ No ☐ Yes	Any surgery:_____
☐ No ☐ Yes	Backache	☐ No ☐ Yes	Other:_____
☐ No ☐ Yes	Bone or joint injury	**FOOD HANDLERS ONLY:**	
☐ No ☐ Yes	Tingling, numbness, pain in hands, wrists, elbows, or shoulders	☐ No ☐ Yes	Change in bowel habits
		☐ No ☐ Yes	Stomach or abdominal pain

TUBERCULOSIS SYMPTOM REVIEW - Complete below to the following conditions that you have had since your last health evaluation.

☐ No ☐ Yes	Cough lasting more than 3 weeks	☐ No ☐ Yes	Excessive fatigue/malaise
☐ No ☐ Yes	Coughing up blood	☐ No ☐ Yes	Recent unprotected close contact with a person with TB
☐ No ☐ Yes	Unexplained/unintended weight loss (> 5 LBS)		
☐ No ☐ Yes	Night sweats (not related to menopause)	☐ No ☐ Yes	A history of immune dysfunction or are you receiving chemotherapeutic or immunosuppressant agents
☐ No ☐ Yes	Fever/chills		
☐ No ☐ Yes	Excessive sputum		

ANNUAL INFLUEZA STATUS - if declining, you must wear a mask starting November 1st (Season is typically from July-April)

Date Received:	Facility Received at:	**OR**	☐ **Declination Signed**	Date Declined:

COMMENTS

_____

_____

_____

_____

The answers to the questions contained in this questionnaire are to the best of my knowledge. I understand that this annual health questionnaire does not take the place of regular visits to a personal, primary care physician.

Workforce Member Signature:_____ Date:_____

E2

ANNUAL HEALTH QUESTIONNAIRE & SCREENING

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C No.

TUBERCULOSIS HISTORY/SCREENING (must be < 12 months from annual date)

☐ Positive TB Symptom Review with Clinical Evaluation
☐ Sent for CXR:_____(Date)
Results_____
Remove from duty ☐ No ☐ Yes_____(Date)

Document of Positive ☐ TST or ☐ BAMT/IGRA
History of BCG ☐ No ☐ Yes
History of TB/LTBI Tx ☐ No ☐ Yes
Treatment _____X_____months

TUBERCULIN SKIN TEST RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal

DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS (Indicate: - Reactor - Non-Reactor - Converter)
	ANNUAL								mm	

OR

DATE DRAWN	BAMT / IGRA	DATE RESULTED	(INITIALS)	RESULT	STATUS
	☐ GFT-GIT OR ☐ T-SPOT				

NEW CONVERSION	CXR DATE	RESULT	TREATMENT
☐ Latent TB Infection ☐ ACTIVE DISEASE- must remove from duty			☐ NO ☐ YES DATE STARTED TREATMENT: _____

RESPIRATORY FIT TESTING (must be < 12 months from annual date)

Date: ☐ **Pass** ☐ **Fail** ☐ **PAPR** ☐ **N/A** (Job duty does not involve airborne precautions or require a respirator.)

EDUCATION/REFERRAL INFORMATION

☐ Reviewed immunization history and declination status. ☐ Recommended annual exam with primary care provider.
☐ Referred to primary care provider for treatment:_____.
☐ Referred to EHS Provider for positive findings:_____.

COMMENTS:

FOR HEALTHCARE PROVIDER:

☐ I attest that all dates and immunizations listed above are correct and accurate.

Date:	Physician or Licensed Healthcare Professional Signature:	Print Name:
Facility Name/Address:		Phone #:

OR

FOR WORKFORCE MEMBER:

☐ Required source documents attached.

Workforce Member Signature:	Date:

DHS-EHS STAFF ONLY

☐WFM completed annual health screening.		Date of clearance:
Signature :	Print Name:	Today's Date:

GENERAL INFORMATION ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C No.

GENERAL INFORMATION

Workforce member (WFM) must complete health screening annually **by the end of the month of last health screening**. Annual health surveillance shall be performed to ascertain that WFM is free from infectious disease and is able to perform their assigned duties.

The health screening consists of:

1. Annual health questionnaire
2. Tuberculosis surveillance
3. Respiratory Fit Testing, if needed
4. Review of immunizations and provide recommended immunizations as needed, or obtain declination forms for declined immunizations

Annual health screening will be provided to County workforce members and volunteers at no charge. Non-County WFM and students must obtain health screening from their physician or school, as applicable; and provide DHS Employee Health Services (EHS) a health screening clearance certificate (**E2- Annual Health Questionnaire and Screening)** including supporting documentation(s) as applicable. Consent must be obtained from minor's parent or legal responsible person to obtain health records. Health screening for contract staff will be provided in accordance with the terms of the contract. Fees and costs for these services shall be billed to the contractor as appropriate.

No person will be allowed to work inside County medical facility without documentation of health clearance or required health screening.

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-EHS form(s) and ensure confidentiality of non-County WFM health information.

Upon request by DHS-EHS, the non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours as applicable.

All non-DHS/non-County WFM health records are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing health information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

K-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
DECLINATION FORM

FOR NON-DHS/NON-COUNTY WFM

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	E or C#.
E-MAIL ADDRESS:	HOME/CELL PHONE#:	DHS FACILITY:	DEPT/WORK AREA/UNIT:
JOB CLASSIFICATION:	NAME OF SCHOOL/EMPLOYER/AGENCY/SELF:	AGENCY CONTACT PERSON:	AGENCY PHONE:

Please check in the section(s) as apply AND indicate reason for the declination.

I. ☐ 8 CCR §5199. Appendix C1 - Vaccination Declination Statement

Check as apply: ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella

I understand that due to my occupational exposure to aerosol transmissible diseases (ATD), I may be at risk of acquiring infection as indicated above. I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. If not immune, I must be immunized (unless medically contraindicated) or risk being restricted from areas of the health facility. I understand that by declining the vaccine(s) if medically contraindicated, I continue to be at risk of acquiring the above infection(s), a serious disease. If in the future I continue to have occupational exposure to ATD and want to be vaccinated, it is the responsibility of your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

II. ☐ 8 CCR §5193. Appendix C1 - Vaccination Declination Statement

☐ Tdap/Td **Reason for declination:** _____

☐ Seasonal Influenza: I am aware that I will be required to wear a surgical mask whenever I have to work within an area that provides patient care/services during influenza season.

Reason for declination *(check as apply):*

☐ I believe I can get the flu if I get the shot
☐ I have severe reactive to previous vaccine
☐ I have history of Guillain-Barré syndrome within 6 weeks after previous vaccine
☐ I do not like needles
☐ I do not wish to say why I decline
☐ Other: _____

III. ☐ 8 CCR §5193. Appendix A - Hepatitis B Vaccine Declination

I understand that due to my occupational exposure to blood or other potentially infectious material (OPIM), I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to me. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with Hepatitis B vaccine, it is the responsibility of your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

IV. ☐ Specialty Asbestos Surveillance Declination

I understand that due to my occupational exposure to asbestos at a combined total of 30 or more days a year warrant medical surveillance. I am eligible and have been given the opportunity to enroll in the Medical Surveillance Program. This will enable me to receive specific initial, periodic and exit medical examinations, at no charge to me and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this strongly recommended enrollment, I will not be medically monitored for occupational exposure to this hazard. I also understand that if in the future I continue to have

PLEASE SIGN ON PAGE 2

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	E or C #:

occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, to contact your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

V. ☐ Specialty Hazardous Drug/ Anti-Neoplastic Surveillance Declination

I am aware that handling hazardous drugs / antineoplastic may cause adverse health effects, and workforce members of reproductive capability must confirm in writing that they understand the risks of handling hazardous drugs. I understand that due to my occupational risk I am eligible and have been given the opportunity to enroll in the Medical Surveillance Program. This will enable me to receive specific initial, periodic and exit medical examinations, at no charge to me and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this strongly recommended enrollment, I will not be medically monitored for occupational exposure to this hazard. I also understand that if in the future I continue to have occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program to contact your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

VI. ☐ Specialty Hearing Conservation Surveillance Declination

I understand that due to my occupational exposure that equals or exceeds an 8-hour time-weighted average of 85 decibels warrant medical surveillance. I am eligible and have been given the opportunity to enroll in the Medical Surveillance Program. This will enable me to receive specific initial, periodic and exit medical examinations, at no charge to me and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this strongly recommended enrollment, I will not be medically monitored for occupational exposure to this hazard. I also understand that if in the future I continue to have occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, to contact your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

VII. ☐ Microbiologist Only

Meningococcal vaccine is recommended to microbiologists who are routinely exposed to isolates of *Neisseria meningitidis.* Both MenACWY and MenB should be provided and boost with MenACWY every 5 years if risk continues. If in the future I continue to have occupational exposure risk and want to be vaccinated, it is the responsibility of your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

SIGN BELOW: By signing this, I am declining as indicated on this form.

WORKFORCE MEMBER SIGNATURE		DATE/TIME
SCHOOL/AGENCY/EHS STAFF (PRINT NAME)	SCHOOL/AGENCY/EHS SIGNATURE	DATE/TIME

N-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

RESPIRATORY FIT TEST RECORD

FOR NON-DHS/NON-COUNTY WFM

☞ **GENERAL INFORMATION on last page**

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

JOB TITLE	DHS FACILITY	DEPT/DIVISION	WORK AREA/UNIT	SHIFT

E-MAIL ADDRESS	WORK PHONE	CELL/PAGER NO	SUPERVISOR NAME

NAME OF SCHOOL/EMPLOYER *(If applicable)*	PHONE NO.	CONTACT PERSON

RESPIRATOR, QUESTIONNAIRE, MEDICAL EVALUATION

RESET FORM N-NC

EQUIPMENT TYPE:	MANUFACTURER:	MODEL:	SIZE:
N95	**Kimberly-Clark**	☐ **PFR95-174** ☐ **PFR95-170**	☐ **Small** ☐ **Regular**

Based on review of the respirator health questionnaire: ☐ 8 CCR §5144 (Form O-NC) ***OR*** ☐ 8 CCR §5199 (Form P-NC), this individual is:

☐ Medically approved for only the following types of respirator subject to satisfactory fit test:

- ☐ 1. Disposable Particulate Respirators
- ☐ 2. Replaceable Disposable Particulate Respirators: ☐ a. Half-Facepiece ☐ b. Full-Facepiece
- ☐ 3. Powered Air Purifying Respirators (PAPRs): ☐ a. Tight Fitting
- ☐ 4. Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

List any facial fit problem conditions that apply to you (e.g., beard growth, sideburns, scars, deep wrinkles): _____

_____

TASTE THRESHOLD SCREENING (NO food, drink, smoke, gum X 15 minutes before testing)

(Bitrex or Saccharin): ☐ X 10 ☐ X 20 ☐ X 30 ☐ Fail

RESPIRATOR FIT, PRESSURE FIT CHECK, COMFORT

	ATTEMPT #1	ATTEMPT #2	ATTEMPT #3
Fit Check: ☐ **POSITIVE** and/or	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
☐ **NEGATIVE** pressure	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Overall Comfort Level	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Ability to Wear Eyeglasses	☐ Pass ☐ Fail ☐ NA	☐ Pass ☐ Fail ☐ NA	☐ Pass ☐ Fail ☐ NA

FIT TEST

	ATTEMPT #1	ATTEMPT #2	ATTEMPT #3
Normal Breathing *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Deep Breathing *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Turning Head Side to Side *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Moving Head Up and Down *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Talking – Rainbow Passage *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Bending Over *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Normal Breathing *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail

COMMENTS: _____

_____

_____

_____

CONTINUE ON NEXT PAGE

N-NC

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

Workforce member failed fit testing. A powered air-purifying respirator (PAPR) must be provided to workforce member.
WFM trained on PAPR use. N/A

PASS Pre-Placement FIT Test on: _____ **PASS Annual FIT Test on:** _____

ACKNOWLEDGMENT OF TEST RESULTS

I have undergone fit testing on the above respirator. I have been instructed in and understand the proper fitting, use and care of the respirator.

Workforce Member Signature:_____Date:_____

FIT Test Trainer (Print Name):_____Signature:_____Date:_____

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION

Pursuant to Title 8 of the California Code of Regulations, Sections 5144 and 5199 (8 CCR §5144 and §5199), all workforce member (WFM) who are required to use respiratory protection must be fit tested with the same make, model, style, and size of respirator to be used. Fit testing procedures for respirators must be conducted for the following:

- Initial fit test must be conducted after the WFM has passed medical evaluation and clearance.
- Newly hired/assigned workforce members who have passed medical evaluation and clearance.
- When new style of respirator face piece is to be worn by WFM.
- Annual fit test for all WFM required to wear a respirator.
- WFM reports, or the Physician or Licensed Health Care Professional (PLHCP), supervisor, or Program Administrator makes visual observations of changes in the workforce member's physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, facial hair, dental changes, cosmetic surgery, or an obvious change in body weight.
- WFM must be given a reasonable opportunity to select a different respirator face piece and be re-fit tested, if required.
- If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM medical information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing health information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 CFR Part 1635

P-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
NON-DHS/NON-COUNTY WORKFORCE MEMBER
8 CCR SECTION 5199 – APPENDIX B
ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

☞ **GENERAL INFORMATION on last page**

Questionnaire for N95 Respirator

COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED

This Appendix is Mandatory if the Employer chooses to use a Respirator Medical Evaluation Questionnaire other than the Questionnaire in Section 5144 Appendix C (Form O-NC).

To the PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Workforce member must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the WORKFORCE MEMBER: Can you read and understand this questionnaire (check one): ☐ Yes ☐ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please complete this questionnaire in PEN and present to the staff at the examination clinic. **To protect your confidentiality, it should not be given or shown to anyone else.** On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

SECTION 1

The following information must be provided by every workforce member who has been selected to use any type of respirator.

PLEASE PRINT LEGIBLY

TODAY'S DATE:			
LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE
HEIGHT FT IN	WEIGHT LBS	JOB TITLE	HSN NO.
PHONE NUMBER	Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No	

Check type of respirator you will use (you can check more than one category):

☐ N, R, Or P disposal respirator (filter-mask, non-cartridge type only)

☐ Other type (specify): _____

Have you worn a respirator? ☐ Yes ☐ No	If "yes", what type:

SECTION 2

Questions 1 through 6 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES", "NOT SURE" or "NO").

YES	NOT SURE	NO	
			1. Have you ever had the following conditions?
☐	☐	☐	a. Allergic reactions that interfere with your breathing?

CONTINUE ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

YES	NOT SURE	NO	
			If "yes," what did you react to? _____
☐	☐	☐	b. Claustrophobia (fear of closed-in places)
			2. **Do you currently have any of the following symptoms of pulmonary or lung illness:**
☐	☐	☐	a Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐	☐	b. Have to stop for breath when walking at your own pace on level ground
☐	☐	☐	c. Shortness of breath that interferes with your job
☐	☐	☐	d. Coughing that produces phlegm (thick sputum)
☐	☐	☐	e. Coughing up blood in the last month
☐	☐	☐	f. Wheezing that interferes with your job
☐	☐	☐	g. Chest pain when you breath deeply
☐	☐	☐	h. Any other symptoms that you think may be related to lung problems: _____
			3. **Do you currently have any of the following cardiovascular or heart symptoms?**
☐	☐	☐	a. Frequent pain or tightness in your chest
☐	☐	☐	b. Pain or tightness in your chest during physical activity
☐	☐	☐	c. Pain or tightness in your chest that interferes with your job
☐	☐	☐	d. Any other symptoms that you think may be related to heart problems: _____
			4. **Do you currently take medication for any of the following problems?**
☐	☐	☐	a. Breathing or lung problems
☐	☐	☐	b. Heart trouble
☐	☐	☐	c. Nose, throat or sinuses
☐	☐	☐	d. Are your problems under control with these medications?
			5. **If you've used a respirator, have you ever had any of the following problems while respirator is being used?** ***(If you've never used a respirator, check the following space and go to question 6).***
☐	☐	☐	a. Skin allergies or rashes
☐	☐	☐	b. Anxiety
☐	☐	☐	c. General weakness or fatigue
☐	☐	☐	d. Any other problem that interferes with your use of a respirator
☐	☐	☐	6. **Would you like to talk to the health care professional about your answers in this questionnaire?**

Workforce Member Signature	Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL TO COMPLETE NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

GENERAL INFORMATION

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5199
Medical evaluation: DHS-EHS or non-DHS/non-County workforce member (WFM) School/Employer shall provide a medical evaluation, in accordance with 8 CCR §5144(e) of these orders, to determine the workforce member's (WFM) ability to use the respirator before the WFM is fit tested or required to use the respirator. For WFM who use respirators solely for compliance with subsections (g)(3)(A) and subsections (g)(3)(B), this alternate questionnaire may be used.

8 CCR §5144(e)

1. General. DHS-EHS or non-DHS/non-county WFM School/Employer shall provide a medical evaluation to determine the WFM's ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
   b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part A.
3. Follow-up medical examination.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall ensure that a follow-up medical examination is provided for a WFM who gives a **positive response to any question among questions 1 through 8 in Section 2, Part A** of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
   b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as health records shall be maintained and filed at DHS.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

Health records will be maintained by DHS-EHS or non-DHS/non-County WFM School/Employer and kept for thirty (30) years after the workforce member's employment/assignment ends, in accordance with State and Federal medical records standards and DHS policies and procedures.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at http://www.dir.ca.gov/title8/5144.html and http://www.dir.ca.gov/Title8/5199.html